c.) Remarks

Claim 8 has been amended in order to recite the invention with the specificity required by statute and claims 6 and 7 have been cancelled. Claims 9-12 are added in order to more specifically recite various preferred embodiments of the present invention. Finally, the title has been amended in conformity with the Official Filing Receipt. Accordingly, no new matter has been added.

Claims 6-8 are rejected under 35 U.S.C. §112, second paragraph, as being of improper dependent form for failing to further limit the subject matter of a previous claim. The rejection is addressed by foregoing amendment to claim 8 and cancellation of claims 6 and 7.

Claim 6 is rejected under 35 U.S.C. §101 as improperly reciting a process. Claims 6 and 7 are rejected for nonstatutory obviousness-type double patenting over claims 1-11 of U.S. Patent No. 5,484,920. Claims 6 and 7 are also rejected under 35 U.S.C. §102(b) as being anticipated by Suzuki et al. (U.S. Patent No. 5,587,378; 1996) in light of Trenkwalder (*Clinical Neuroscience*, 1998). These rejections are all mooted by the above cancellation of claims 6 and 7.

Claims 1-6 are rejected under 35 U.S.C. §103(a) as being obvious over Suzuki in view of Trenkwalder.

The Examiner states that Suzuki teaches a method for treating Parkinson's Disease (hereinafter "PD") by administering (E)-8-(3,4-dimethoxystyryl)-1,3-diethyl-7-methylxanthine). According to the Examiner,

> Trenkwalder makes it clear that these disorder [restless legs syndrome and nocturnal myoclonus] are linked to PD.

This rejection is respectfully traversed.

Applicants' detailed review of Trenkwalder reveals that it actually teaches the frequency of sleep complaints in patients with PD is estimated between 60-90%. However, Trenkwalder does not teach a prevalence of restless legs syndrome (hereinafter "RLS") and nocturnal myoclonus among patients of PD. That is, in fact the reference does not teach any relationship between RLS or nocturnal myoclonus and PD.

Indeed, those of ordinary skill are well-aware there is, to the contrary, no such relationship. For instance, Tan et al. (*J. Neurol. Sci.*, Vol. 196 (2002) 33-6)[1] clearly teaches RLS and PD do not share the same pathophysiologic mechanism. Moreover, Tan shows RLS is not a form of PD based on their clinical and functional imaging data. Further, it is understood that about 80% of patients with RLS have nocturnal myoclonus (see page 11, lines 9-12 of the present specification). These facts evidence that RLS and nocturnal myoclonus are not linked to PD.

In view of the above amendments and remarks, Applicants submit that all of the Examiner's concerns are now overcome and the claims are now in allowable condition. Accordingly, reconsideration and allowance of this application is earnestly solicited.

Claims 1-5 and 8-12 remain presented for continued prosecution.

---

[1] Referenced at specification page 2, lines 24-28 and cited in the accompanying Information Disclosure Statement.

Applicants' undersigned attorney may be reached in our New York office by telephone at (212) 218-2100. All correspondence should continue to be directed to our below listed address.

Respectfully submitted,

/Lawrence S. Perry/
Lawrence S. Perry
Attorney for Applicants
Registration No. 31,865

FITZPATRICK, CELLA, HARPER & SCINTO
30 Rockefeller Plaza
New York, New York 10112-3801
Facsimile: (212) 218-2200

LSP\ac

FCHS_WS 1903680_1.DOC